

**Scot Laurie, MD, P.A.**

**Allergy & Asthma Center at Waxahachie**

**Acknowledgement of Receipt of Notice of Privacy Practices**

Our practice reserves the right to modify the privacy practices outlined in the notice.

**Signature**

I have reviewed this office's Notice of Privacy Practices, which explains how my medical Information will be used and disclosed. I undersand that I am entitled to receive a copy of your Notice of Privacy Practices.

\_\_\_\_\_  
Name of Patient (Print or Type)

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient Representative  
(Required if the patient is a minor or an adult who is unable to sign this form)

\_\_\_\_\_  
Relationship of Patient Representative to Patient